

Using Medicaid to Fund a Wide Range of Community Health Worker Services

Community Health Workers Promote Whole-Person Health

Community health workers (CHWs) are frontline public health workers who are trusted members of their communities or have an especially close understanding of the community served.¹ CHWs are employed by hospitals, community health centers (CHCs), community-based organizations (CBOs), and other individual and community service providers. Their titles and roles vary, and their scope of work includes a wide range of services described by the [CHW Core Consensus \(C3\) Project](#). There is a significant [body of evidence](#) that CHWs are effective in these roles,² particularly when serving communities that are medically underserved or face social and economic barriers to health. Studies have shown that CHW programs help control and improve health conditions including asthma,³ hypertension,⁴ HIV,⁵ diabetes,⁶ mental health conditions,⁷ and chronic diseases;⁸ promote access to preventive care,⁹ and reduce health inequities;^{10,11} and lower health care costs¹² and provide a return on investment.¹³ **This brief will describe why and how state policymakers should cover a wide range of CHW services in their Medicaid programs, aligning with the C3 Project's Core CHW Roles** (see sidebar).

CHWs Are Well-Situated to Serve Medicaid Beneficiaries

CHWs have been improving the health of communities for decades, and health care providers, payers, and patients can greatly benefit from the full scope of services CHWs provide. As hospitals and health systems increasingly seek to build relationships and trust within their patient communities, CHWs are experts at building bridges between the community and clinical systems.¹⁴ They bring tremendous value as trusted messengers, connecting with individuals whom the traditional health care system may miss or exclude: those who face language, transportation, or other logistical barriers; those who mistrust the medical system; and those unable to navigate or access the online systems that are increasingly common in health care.

[Medicaid](#), a public health insurance program for people with low incomes that covers 1 in 5 Americans,¹⁵ is increasingly covering services provided by CHWs because they have historically been effective at meeting the needs of low-income, historically marginalized, medically underserved populations, which includes a large proportion of Medicaid-eligible individuals. Because states administer their own Medicaid programs, they have considerable flexibility to define who is eligible, what benefits are available to enrollees, and how payments are structured. State Medicaid programs are not federally mandated to provide CHW services, but they can use several existing policy tools to authorize Medicaid payment for CHW services as an additional benefit. A summary of these tools can be found in the sidebar on the following page.

C3 PROJECT Core CHW Roles

Cultural Mediation
Among Individuals,
Communities, and
Health and Social
Service Systems

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Providing Culturally
Appropriate Health
Education and
Information

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Care Coordination,
Case Management, and
System Navigation

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Providing Coaching and
Social Support

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Advocating for
Individuals and
Communities

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Building Individual and
Community Capacity

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Providing Direct Service

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Implementing Individual
and Community
Assessments

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Conducting Outreach

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Participating in
Evaluation and
Research

In a recent survey of Medicaid budgets in all 50 states, more than half of states reported initiatives in place for Fiscal Year (FY) 2021 or planned for FY 2022 to expand their state's CHW workforce. In addition to positive health outcomes, well-designed CHW programs have been shown to save as much as \$2.47 in Medicaid spending for every dollar spent.¹⁶ This is because CHWs promote early detection and ongoing management of chronic conditions, connect individuals into social services that address a range of social determinants of health improving care coordination, and helping prevent illness or hospitalizations.

Financing CHWs through Medicaid can control costs while improving care coordination, culturally responsive care, connections to services, and other outcomes to promote health equity.

Widening the Range of CHW Services in Medicaid

States funding CHW services through Medicaid have wide latitude to determine which services will be covered. Some states have taken a narrow approach to Medicaid coverage of CHW services, limiting services to those involving direct patient care. For example, Minnesota was the first state to allow direct Medicaid reimbursement for CHW services after a bill was passed by the Minnesota Legislature in 2007 and a State Plan Amendment (SPA) was subsequently approved by the Centers for Medicare and Medicaid Services (CMS). Under this SPA, CHWs are paid for "diagnosis-related patient education and self-management" under the supervision of a licensed medical professional, which narrows the scope of CHWs to patient education.

While CHWs add significant value even with a narrower scope, narrower approaches omit several services that positively impact Medicaid beneficiaries and that CHWs, with a shared lived experience and close relationship to the community, are uniquely positioned to provide. Narrowed scopes also risk over-medicalizing the CHW workforce by only covering services that are clinically oriented, neglecting the non-clinical support services that often significantly impact health outcomes. For example, when helping someone with their diabetes care, CHWs can provide more than education on medication management—they can accompany patients to help choose culturally appropriate low-sugar foods at the grocery store or even cook with patients. This accompaniment of patients on their journey to wellbeing can increase the likelihood of the patient making long-term changes to their lifestyle but may not be covered by Medicaid programs that restrict CHWs to more limited scopes of work. As policymakers integrate CHWs into their Medicaid programs, they should preserve what makes CHWs unique and effective, and resist making them an extension of clinic-based providers funded by Medicaid.

To maximize CHW impacts on the health and wellbeing of Medicaid beneficiaries and communities, state Medicaid programs should pay for the broad range of services that CHWs are experts at delivering. States can cover several CHW services in both fee-for-service and managed care payment models,¹⁷ by expanding the activities provided by CHWs in a fee-for-service model, or by including a broad range of activities for CHWs in Medicaid contracts with managed care organizations (MCOs). States are using different Medicaid policy tools to successfully expand the scope of services CHWs can provide, such as Oregon's 1115 waiver¹⁸ California's SPA,¹⁹ and New Mexico's MCO contract requirements (see next page).

Selected state policy tools for Medicaid coverage of CHW services

STATE PLAN AMENDMENTS:

An updated agreement between a state and the federal government describing how that state administers its Medicaid program. SPAs can be used to reimburse certain CHW services, including preventive services.

SECTION 1115 WAIVERS:

Experimental, pilot, or demonstration projects that are likely to assist in promoting the objectives of the Medicaid program. States have used these waivers to temporarily reimburse for defined CHW services.

MANAGED CARE CONTRACTS:

Contracts between a state Medicaid agency and Managed Care Organizations (MCOs) may include requirements for services covered and other factors related to CHWs.

OTHER HEALTH SYSTEM TRANSFORMATION EFFORTS:

States are exploring a wide range of other health care delivery models to improve outcomes while reducing costs, and many of these models have potential to incorporate CHWs as a key member of the workforce.

For more information, see NACHW's 2020 report [Sustainable Financing of Community Health Worker Employment](#).

New Mexico MCO Contract Requirements



New Mexico's Medicaid program utilized managed care contract requirements to promote payments to CHWs for a broad array of services. The state's contracts with MCOs require that they directly hire or contract with CHWs to provide services to a gradually increasing percentage of their members (now 3%). The plans pay CHWs for "care coordination activities," which include health education delivered in a culturally responsive manner, informal counseling, navigation, and translation services (among others).²⁰ The contracts establish a minimum set of CHW services MCOs must cover, but also provides flexibility for MCOs to provide additional services. One study found a significant reduction in the use of ambulatory services compared to the comparison group after incorporating CHWs with a broad scope of activities into management plans, improving access to preventive and social services while reducing costs.²¹

Conclusion and Recommendations

By covering a wide range of CHW services, state Medicaid programs can more effectively address social determinants of health and health inequities, positioning CHWs to ensure treatment of the whole person and advance community-level health, rather than limiting them to condition-specific activities for individual patients. CHWs can help increase savings while improving care coordination, culturally responsive care, connections to services, and other outcomes to promote health equity. There is no one-size-fits-all approach to covering CHW services through Medicaid, but by maximizing the scope of services covered, states can better support CHWs to serve patients and communities. Below is a short list of recommendations for state policymakers; additional recommendations will be provided in a forthcoming policy paper.

States that do not currently incorporate CHWs into their Medicaid programs should make policy changes to cover CHW services. Medicaid programs can seek federal approval through various policy tools to leverage Medicaid funds for CHW services. State legislatures can also require their Medicaid agencies to cover CHW services and can provide funding when necessary.

States that have already incorporated CHWs into their Medicaid programs should cover the broad range of CHW services, aligned with the C3 Project Core CHW roles.

- States using managed care models can cover a wider range of CHW services in Medicaid contracts with MCOs, and other value-based payment models can further advance this goal.
- States using fee-for-service models should reimburse as many CHW services as possible but will face limitations due to a lack of billing codes for a comprehensive set of CHW activities.

All states should ensure CHW leadership and participation in policymaking decisions affecting the CHW workforce. State planning efforts should include professional organizations such as the National Association of Community Health Workers (NACHW), state networks of CHWs, community-based organizations, and other stakeholders so that Medicaid agencies can capture the vast array of activities that CHWs can effectively provide.

All states should grow and maintain additional funds for CHW programs and services. Medicaid financing must supplement, but not supplant, other sources of funding for CHW services. States should use multiple policy tools and funding streams to support the full breadth of CHW activities to advance the health of their communities.

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ENDNOTES

- 1 American Public Health Association. "Community Health Workers." Accessed December 14, 2022. <https://www.apha.org/apha-communities/member-sections/community-health-workers>
- 2 Association of State and Territorial Health Officials and National Association of Community Health Workers. "Community Health Workers: Evidence of Their Effectiveness." Association of State and Territorial Health Officials. Accessed December 14, 2022. <https://www.astho.org/globalassets/pdf/community-health-workers-summary-evidence.pdf>
- 3 Jonathan D. Campbell, et al. "Community Health Worker Home Visits for Medicaid-Enrolled Children With Asthma: Effects on Asthma Outcomes and Costs." American Journal of Public Health. 105 no.11 (November 2015): pp. 2366-2372. <https://doi.org/10.2105/AJPH.2015.302685>
- 4 Jeannette M. Beasley, et al. "A Community Health Worker-Led Intervention to Improve Blood Pressure Control in an Immigrant Community With Comorbid Diabetes: Data From Two Randomized, Controlled Trials Conducted in 2011-2019." American Journal of Public Health. 111 no.6 (June 2021): pp.1040-1044. <https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2021.306216?journalCode=ajph>
- 5 Sonja Kenya, et al. "Using Community Health Workers to Improve Clinical Outcomes Among People Living with HIV: A Randomized Controlled Trial." AIDS and Behavior. No.17 (November 2013): pp. 2927-2934. <https://doi.org/10.1007/s10461-013-0440-1>
- 6 Walter Palmas, et al. "Community Health Worker Interventions to Improve Glycemic Control in People with Diabetes: A Systematic Review and Meta-Analysis." Journal of General Internal Medicine. 30 no.7 (July 2015): pp. 1004-12. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4471021/>
- 7 Addie Weaver and Adrienne Lapidus. "Mental Health Interventions with Community Health Workers in the United States: A Systematic Review." Journal of Health Care for the Poor and Underserved. 29 no.1 (February 2018): pp. 159-180. <https://pubmed.ncbi.nlm.nih.gov/29503292/>
- 8 Kyounghee Kim, et al. "Effects of Community-Based Health Worker Interventions to Improve Chronic Disease Management and Care Among Vulnerable Populations: A Systematic Review." American Journal of Public Health. 106 no.4 (April 2016): pp. e3-e28. <https://pubmed.ncbi.nlm.nih.gov/26890177/>
- 9 Matthew J. O'Brien, et al. "Community Health Worker Intervention to Decrease Cervical Cancer Disparities in Hispanic Women." Journal of General Internal Medicine. No.25 (July 2010): pp. 1186-1192. <https://doi.org/10.1007/s11606-010-1434-6>
- 10 Shreya Kangovi, et al. "Community Health Worker Support for Disadvantaged Patients With Multiple Chronic Diseases: A Randomized Clinical Trial." American Journal of Public Health. 107 no.10 (October 2017): pp. 1660-1667. <https://pubmed.ncbi.nlm.nih.gov/28817334/>
- 11 Marshall H. Chin, et al. "Interventions to Reduce Racial and Ethnic Disparities in Health Care." Medical Care Research and Review. 65. Supp. 5. (October 2007): pp: 7S-28S. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2366039/>
- 12 RTI International. "Health Care Innovation Awards (HCIA) Meta-Analysis and Evaluators Collaborative: Third Annual Report." (Center for Medicaid and Medicare Services, 2018). Accessed December 14, 2022. <https://downloads.cms.gov/files/cmmi/hcia-metaanalysisisthirdannualrpt.pdf>
- 13 Shreya Kangovi, et al. "Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment." Health Affairs. 39 no.2 (February 2020): pp. 207-213. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00981>
- 14 Kathleen Gifford, et al. "States Respond to COVID-19 Challenges but Also Take Advantage of New Opportunities to Address Long-Standing Issues: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2021 and 2022." Kaiser Family Foundation. October 27, 2021. Accessed December 14, 2022. <https://www.kff.org/report-section/states-respond-to-covid-19-challenges-but-also-take-advantage-of-new-opportunities-to-address-long-standing-issues-social-determinants-of-health/>
- 15 Kaiser Family Foundation. "Health Insurance Coverage of the Total Population." Accessed December 14, 2022. <https://www.kff.org/other/state-indicator/total-population/>
- 16 Shreya Kangovi, et al. "Evidence-Based Community Health Worker Program Addresses Unmet Social Needs And Generates Positive Return On Investment." Health Affairs. 39 no.2 (February 2020): pp. 207-213. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00981>
- 17 Under the fee-for-service model, the state pays providers for each covered service that they provide for a Medicaid beneficiary. Under managed care models, the state pays a set capitated payment (often calculated per-member, per-month) to a managed care plan in exchange for the plan providing all Medicaid services that are included in the plan's contract with the state. While Medicaid programs historically used fee-for-service, states have increasingly adopted managed care models and the majority of Medicaid beneficiaries are now in managed care plans. This shift in payment models away from fee-for-service and toward value-based payment presents a greater opportunity to cover a wide range of CHW services. For more information, see <https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/>
- 18 Oregon Health Authority. "Oregon Health Plan 1115 Demonstration Waiver." Accessed December 14, 2022. <https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/OHP-Waiver.aspx>
- 19 California Department of Health Care Services. "Community Health Workers." Accessed at December 14, 2022. <https://www.dhcs.ca.gov/community-health-workers>
- 20 Sarah Klein, et al. "How New Mexico's Community Health Workers Are Helping to Meet Patients' Needs. The Commonwealth Fund: Primary Care for Low-Income Populations." February 2020. <https://www.commonwealthfund.org/publications/case-study/2020/feb/new-mexico-community-health-workers>
- 21 Diane Johnson, et al. "Community health workers and Medicaid managed care in New Mexico." Journal of Community Health. 37 no.3 (June 2012): pp. 563-71. <https://pubmed.ncbi.nlm.nih.gov/21953498/>